MINUTES
of the
THIRD MEETING
of the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

September 30, 2013
Adelante Development Center
3900 Osuna Road NE
Albuquerque

The third meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee was called to order by Senator Benny Shendo, Jr., chair, at 9:15 a.m. on Monday, September 30, 2013, at Adelante Development Center in Albuquerque.

Present
Sen. Benny Shendo, Jr., Chair
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Rep. Sandra D. Jeff
Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Edward C. Sandoval

Absent
Rep. Phillip M. Archuleta, Vice Chair

Guest Legislator
Rep. Miguel P. Garcia

Staff
Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS
Branden Ibarra, LCS

Guests
The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Monday, September 30

Call to Order and Introductions

Senator Shendo asked members and staff to introduce themselves.

Welcome

Mike Kivitz, president and chief executive officer (CEO) of Adelante Development Center, Inc., welcomed members of the Behavioral Health Subcommittee and the public and described the work of the nonprofit organization, which was founded in 1978. Adelante currently provides a wide variety of services, including employment, vocational and life skills training, residential services and volunteer opportunities for people with disabilities. There are over 1,000 people on Adelante's payroll, including more than 400 in Albuquerque who are disabled, and another 200 at other locations. In serving its role as a community resource, Adelante also operates BackInUse.com, a web site that provides an exchange for rehabilitation and distribution of durable medical equipment.

Native American Behavioral Health Concerns

Maria K. Clark, director of the Pueblo of Jemez Health and Human Services Department, introduced Keahi Kimo Souza, program manager of Jemez Behavioral Health Services. Ms. Souza and Ms. Clark said that federal sequestration has had a huge impact on their delivery of health services, especially on inpatient services, and that they have had to rely more on grants. People are now being put on waiting lists in urgent situations — special needs, domestic violence, assaults, DWI, suicidal ideations — and this has increased utilization of the emergency room, they said. Daily rates have increased, there have been cuts to services and staff layoffs and some clients are being sent out of state in order to receive appropriate care. Restriction of staff training has affected morale, and self-referrals are down because clients fear they will be sent away.

Linda Son-Stone, Ph.D., is CEO of First Nations Community HealthSource in Albuquerque, which was established in 1972 to provide comprehensive medical, dental and behavioral health services to urban Native Americans. Additional services include prevention education to teach people about healthy relationships. The feedback on these classes has been excellent, Dr. Son-Stone said, and there is a critical need to continue them. In New Mexico, a woman is more than twice as likely to be a victim of sexual and/or domestic violence than in other states, Dr. Son-Stone said. Many of these victims are reluctant to seek help, and there is an urgent need to help children who witness domestic violence. Sequestration has eliminated two of First Nations' sexual assault and domestic violence programs, she said.

In response to questions from subcommittee members, Dr. Son-Stone said that her organization has applied for additional grants, but many of the organizations that provide

services have also suffered cutbacks. First Nations treats everybody who presents, she said, and tries to coordinate care with the Native American community from which the client has come. Follow-up is always the goal, she said, but it is also a huge challenge, since many clients do not have a cell phone or permanent address.

Dr. Son-Stone explained that First Nations is Medicaid-certified, and therapy services can be billed, but prevention and care coordination services cannot be billed. One subcommittee member, who said that she has sponsored legislation to obtain funding for tribal domestic violence case training, wants to continue this advocacy, and said that she would like to work with First Nations on this. Another member expressed dismay about case management not being reimbursable. This is wrong, he said; it may save money in the short run but will result in more spending in the long run. Dr. Son-Stone said that in response to the federal Patient Protection and Affordable Care Act (PPACA), First Nations has increased its capacity to enroll for Medicaid and to provide education about available benefits through a Health Resources and Services Administration grant.

Another member asked Ms. Clark about Centennial Care, specifically, why there is push-back against managed care among Native Americans. Working with the state has been a challenge, Ms. Clark told members, and tribal providers have fought hard to retain fee-for-service (FFS). In managed care, participants are locked into one of the four managed care organization (MCO) provider networks. Payment is delayed by the MCO, causing problems with budgeting, she said. With FFS, payment is often made within four days, and an enrolled Native American can go anywhere for service. MCOs get paid "per member per month" (PMPM), and the highest tier is the sickest population — i.e., Native Americans, Ms. Clark said. MCOs are eager to sign up tribal members to get the highest PMPM because they will be paid regardless of whether or not they provide the service. At the Pueblo of Jemez, its program is able to charge the PMPM only if it performs the service. The Pueblo of Jemez is still pushing for reintroduction and passage of House Bill (HB) 376 from the 2013 regular session, which would exempt all Native Americans from mandatory enrollment in Medicaid managed care.

Susy K. Ashcroft, M.A., L.P.C.C./L.A.D.A.C., who is Paiute, is eastern clinical director for the Navajo Nation and has been an advocate for Native Americans for many years. Ms. Ashcroft said she wanted to speak specifically to the interruption in behavioral health services due to the Human Services Department (HSD) audit. Ms. Ashcroft said she knows first-hand that clients are not getting uninterrupted services. The audit, she said, "has destroyed therapeutic alliances that have taken years to build up. It has destroyed the careers and reputations of people I have worked with, and trusted, for many years". Ms. Ashcroft said that there are huge issues of neglect and physical and substance abuse, and that clients can no longer be sent to nearby providers. The pool of providers has been shrinking, she said, and "culturally competent" providers are disappearing. "These changes distress and frighten me", she said. Ms. Ashcroft does not want her health care governed by an MCO whose goal is to save dollars. "We (tribes) have always been sovereign, and you can't tell a sovereign nation what to do."

William Merkle, Ph.D., director of human services at the Pueblo of San Felipe, is a licensed psychologist, and he oversees the pueblo's behavioral health program, which includes several large grants. With the recent addition of a part-time staff psychiatrist and ongoing peer support workers, the Pueblo of San Felipe has established programs for teenagers and for suicide prevention and a new equine therapy pilot project. It is a strong system, Dr. Merkle said, and the concern with MCOs is that the pueblo will no longer be in the driver's seat.

Anthony Yepa, Pueblo of Santo Domingo, director of the behavioral health component of the Kewa Pueblo Health Corporation, said that it was Congress that decided that Native Americans should be treated differently. Many Native American health care organizations are funded by the federal government through the Indian Health Service. Mr. Yepa said that the 15 agencies that were audited were much-needed providers of services. The problem, he said, is that the state has not been monitoring its contractors. If there truly was fraud, why did it take OptumHealth so long to catch up with it? There is a $5.3 billion contract for Centennial Care and its four MCOs, he pointed out, and who will be monitoring these? Mr. Yepa said his social worker at Kewa wanted him to point out to legislators that they (the tribes) are sovereign, they have their own laws, plus federal laws, and there should never be a need for "prior authorization" from the state. Because the state does not acknowledge tribal court commitments, there often are problems getting patients committed to the state hospital, Mr. Yepa added.

Questions/Concerns

Subcommittee members had questions for panel members on the following topics:

Lack of data on behavioral health needs. One member asked if there were any numbers available on how many people are on the street, in the emergency room or in jail because of the disruption of behavioral health services. Another member asked if prisons are being used to take care of mental health needs. Ms. Ashcroft said she believes that the state has collected some data, but does not use the data. She said when she asked about Native American data gathered by the state, she was told that there is not data for how many people end up in crisis in Albuquerque or in Gallup. There is a lot of health disparity, she said. Recently, she asked Local Collaborative 2 for a $500 grant to do a census and study of problems, and she was asked why she wanted to reach out to the drunks. The myth is that they came to town to party and then got into trouble, but no one has any idea what has happened to these people, because there is no data. Another member lamented the lack of funding for services in Gallup, where there are so many bars, and the lack of any attempt to address the damage being inflicted upon families from compulsive gambling. Legislators are here to serve constituents, she said, and there is obvious need, but she remains very disappointed in the system.

HSD disruption of therapeutic alliance. A member asked how the alliance can be rebuilt. Ms. Ashcroft said that the HSD has made decisions about clinical matters, and the agency does not have very many trained clinicians high up in the organization. Native Americans deal with the whole person; traditional culture upholds that, she said. Taking the entire system down was just wrong. Ms. Souza added that the audited agencies had people who were the points of

contact, and the disruption of this therapeutic and personal alliance has been detrimental. Trust is always an issue in Indian country, Ms. Souza said, and it took many years to build. Predictability and follow-through are key, she said. There have been many promises, but there is no follow-up.

Problems of veterans and homelessness. One of the strengths of the Native American community is identification with family, Ms. Souza said, but grief therapy and historical trauma cannot be addressed in fewer than a dozen sessions, and there are limits on services and funding. At the Pueblo of Jemez, there are approximately 200 veterans. The Veterans Health Administration in Albuquerque has a lot of resources, but also a wait list for services. There are cuts in services, and people are being put on wait lists there, she said, and they are told that if they are Native American, they should go back to their tribes.

Tribal involvement with Centennial Care. In response to a member's question about tribes' involvement with the state regarding the Centennial Care strategy, Mr. Yepa said that the state has engaged the tribes, but communication has been a struggle. "Our questions addressed to HSD were not answered by HSD. We had to go to CMS to get our questions answered", Mr. Yepa said. Care coordination will require the MCOs to hire Native Americans to communicate with these communities, he said, and the waiver requires culturally competent services. To date, there have not been details on how this is going to be rolled out. Ms. Clark said that the Pueblo of Jemez did inquire about possible involvement in case management.

Update on Behavioral Health Services

Diana McWilliams, director of the Behavioral Health Services Division (BHSD), HSD, and CEO of the Interagency Behavioral Health Purchasing Collaborative, and Larry Heyeck, HSD deputy general counsel, provided talking points (see handout) to subcommittee members.

Ms. McWilliams described a change in early 2012 to OptumHealth's program integrity protocols, with which it had always been in compliance, she said. There was an "enhancement" to OptumHealth's system that changed how it looked at data, a change that would not necessarily have been noticed by agencies, Ms. McWilliams said. The enhanced system compared providers to peers within the state. Prepayment review and analysis are recommended by the Center for Medicare and Medicaid Services (CMS), she said. Mr. Heyeck added that under the PPACA, there is a move away from the "pay and chase" model to one of predictive analytics in order to better protect money before it goes out the door. There has been up to 10 percent fraud identified at the federal level; in New Mexico, this would translate to $300 million to $400 million in projected waste and abuse, he said. If something looks like suspicious activity, it must be referred by OptumHealth to the Quality Assurance Bureau (QAB) of the HSD and investigated by OptumHealth with desk audits, claims review and analysis, and on-site file audits, Ms. McWilliams said. From the QAB, information may be sent on to the state Attorney General's Office (AGO).

Ms. McWilliams said that OptumHealth will be retained for six months, through June 30, 2014, to manage non-Medicaid behavioral health funds, allowing time for collaborative agencies to bid for a contract to manage these behavioral health dollars. She discussed third-party oversight of behavioral health services from June 30, 2013 through the end of the first quarter of 2014. The HSD is looking at data points, inpatient admissions and crisis and utilization data for this period, she said. If there are any issues with disruption of services, the collaborative should be informed. She assured members that every report will be investigated. Work is under way within the collaborative to put together web site dashboards that will be available to the public. Ms. McWilliams referred subcommittee members to two web sites for behavioral health providers in Arizona, which provide a dashboard of information and data on how the system is performing (see handout). She said that the BHSD will be putting out a request for proposals (RFP) for technical assistance and for monitoring of New Mexico's behavioral health system and to assist providers statewide with billing and clinical documentation.

Questions/Comments

Members had numerous questions for Ms. McWilliams and Mr. Heyeck, grouped into the following categories.

Professional qualifications of Ms. McWilliams and Mr. Heyeck. Ms. McWilliams said she is not a licensed behavioral health provider. She holds a master's degree in public administration and served as a Delaware state legislator for two terms. Ms. McWilliams said she has also run several nonprofit organizations in child care, Planned Parenthood of Delaware and the Rape Crisis Center in Santa Fe. Mr. Heyeck told members that he is a licensed attorney in New Mexico and that he has been involved in health care in both the private and public sectors. He has served as deputy director of the state's Medicaid program, where he oversaw contracts, fraud and abuse; health care financing; and the "nuts and bolts" of managed care. Last week, he was an invited speaker at a Medicaid program integrity workshop.

What is the executive program integrity special project? That is the name given to the internal audit of the 15 behavioral health providers, according to Ms. McWilliams, who said that she did attend a series of meetings of this group from January 5 through March. The meetings were usually held in the Office of the Secretary of Human Services. Several meetings were held in the offices of OptumHealth, she recalled. The member read a list of OptumHealth employees, including the national head of OptumHealth and various state and regional employees, and asked if they were invited to these meetings as well. Yes, replied Ms. McWilliams, because it was OptumHealth that made the referral. Asked if the attorney general attended, she said no, but that his office was given regular updates. Asked if Thomas Aldridge, manager of the Public Consulting Group (PCG) audit, attended any of these meetings, Ms. McWilliams said she thought he attended at least one, but he participated by phone. The January 11 agenda mentions Southwest Counseling Center and La Frontera by name, the member pointed out. Based on the size of those referrals, the HSD was very concerned about being able to cover services, Ms. McWilliams said, so it had to look at where else it might go for help. The HSD did know in November how large the referral was, she said.

Is OptumHealth getting a percentage of recouped payments? Mr. Heyeck described two new rules under the PPACA: the 60-day rule, requiring providers to report overpayments to the MCO and the state; and the lowering of the bar for credible allegations of fraud. All contracts have been changed to align with the PPACA, Mr. Heyeck said, and if the HSD or the AGO receives dollars on a civil claim, the MCO that identified the fraud will get a piece of that restitution.

Four tiers of findings referred to in the PCG audit public summary. A member asked why the audited agencies were required to change management instead of going with the tiered approach established before the audit. Most of the problems did not even require a change in management, per the executive summary that was made public, the member noted. The HSD chose to end 12 agency contracts that were in a PCG category that would not even justify a change in management, the member said. After reading federal regulations, it is clear that there were many choices and total discretion on the part of the secretary of human services in this matter, the member concluded, and the action taken to freeze all payments was not required by the CMS. Mr. Heyeck said that not only the clinical findings, but the conflicts of interest, justified a change in management. The only discretion Secretary of Human Services Sidonie Squier had was to grant good cause exceptions, he said.

Lack of data regarding progress of service provider transition. Several subcommittee members expressed dismay that they still have not received data from the HSD regarding the transition. They are looking for data that compare service levels from before the transition to the present. Ms. McWilliams said that she does have data and that she wants to put the data into a report. She also said she has data on inpatient admissions, which she said have not gone up during the transition. Based on the reports she has received, Ms. McWilliams said, the transition is going well. The retention of providers, or re-hires, is at 90 percent. These numbers can be documented, she said, because the department has rosters in order to meet payroll. There is a transition update spreadsheet that she has with the roster, and she will get that information to the subcommittee. Although the HSD does get monthly summaries from OptumHealth, these month-to-month reports are not helpful, Ms. McWilliams said. Another member noted that without data, it is very hard to judge what is really going on. The subcommittee has never gotten information about behavioral health beyond the glowing assertions. Another member asked if people are falling through the cracks. "We are not denying services to anyone", Ms. McWilliams said. "We will provide you with numbers. We are working on it now, putting together a dashboard. My team is investigating every report and complaint. Therapeutic relationships are very important; they are our number one priority."

Transfer of medical records and document imaging. In response to questions about document imaging of medical records, Mr. Heyeck said that in stipulations he drafted, imaging companies must be secure, maintain confidentiality and be bonded, and their employees must have federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) training. Two companies were chosen: DATAMARK and Document Imaging of the Southwest, both with many years of experience, Mr. Heyeck said. Obtaining the records sometimes was very

difficult, with some former providers taking the records off site and, in some cases, locking them up. A subcommittee member expressed great concern about an email he received with a copy of a form signed by an Arizona provider. He asked what gave an Arizona provider the ability to sign off on this. He said it was his understanding that those files must have a consent form signed by the individual or guardian. There are names in this email that are not encrypted — 2,000 to 3,000 of them he said — and he is concerned that the state has violated the rights of these clients. Also, there is an obligation under HIPAA to notify all of those individuals whose names have been released.

Clarification of email from the CMS. One member received a copy of an email from some members of the New Mexico congressional delegation to the CMS clarifying that, according to the CMS, New Mexico was not at risk for losing Medicaid funding if good cause was granted to the audited providers. The CMS recommended that consumers report their concerns to directly to OptumHealth. Another member reiterated his earlier stance that the state had total discretion and could have taken other options short of putting the agencies out of business. "Why did you do this four months early and cause all this chaos?", he asked. Mr. Heyeck responded that the decision was not made by himself.

Motion to Send a Letter to the Attorney General

A motion was made requesting that the Legislative Health and Human Services Committee send a letter to the attorney general about the unencrypted email. The motion was seconded and passed without objection.

Behavioral Health in the Criminal Justice System

Dr. Nils Rosenbaum is a psychiatrist who works for the Albuquerque Police Department, and, along with Detective Matthew Tinney, is part of a crisis intervention team (CIT), whose goal is early intervention in situations that have the potential to escalate. Dr. Rosenbaum said that the overarching purpose of the CIT is to protect public safety, to divert people away from incarceration whenever possible and to facilitate people getting the services that they need. It is entirely voluntary, he said. The CIT cannot force anyone to do anything. About 25 percent of Albuquerque police officers have been trained in CIT techniques. When a call comes in to the dispatcher, the sergeant on duty decides which team should respond. A caller can ask for a CIT-trained officer. The CIT finds the person who is having the crisis, talks to the person, talks to family members and takes the person to the hospital, if needed. Sometimes what is required to defuse a situation is as simple as providing someone with a new pair of socks, or perhaps the person needs a ride to get an appointment for help with a problem. The CIT facilitates people getting care, Dr. Rosenbaum said.

Detective Tinney said that the CIT provides short-term crisis management. "We help them get into services. We do not have a budget, and we are not a service provider ourselves, but hopefully we can link someone into services", he said. The team provides the human connection, Detective Tinney said, a one-on-one contact that can allow a person to save face during a crisis situation. It can take months to get an appointment with a psychiatrist, he said, and sometimes

the CIT can facilitate a person getting the needed services earlier. Assertive community treatment (ACT) is similar, but it does provide services, he said. ACT is a team-based service that includes case management and psychosocial rehabilitation provided in the community.

Dr. Rosenbaum described the community engagement team (CET) concept, passed by the legislature but vetoed during the last legislative session, as a hybrid between a CIT and ACT that can help address barriers to treatment. It was never designed to be a forced treatment, he said. A CET, as proposed, could be set up by any group and does not require state funding. A CET member can talk to an individual about available services and link that person to those services, Dr. Rosenbaum said. A lot of people do not want to see a psychiatrist, and there are lots of barriers to getting an appointment. A CET member who is clinically trained can be sent in to talk to a person before he or she becomes hospitalized or jailed. Jail is being used as a hospital, said Dr. Rosenbaum. The same percentage of people who used to be institutionalized are now in jail. Albuquerque has a mental health court, Detective Tinney said, and this has been very effective. If an individual is accepted into a court program and follows up with treatment, then the court case will be dropped.

Questions/Concerns

Several members expressed gratitude to Dr. Rosenbaum and Detective Tinney for the important work that they do. One member said he was formerly a crisis intervention officer himself, and the training he received was invaluable. He knows how important it is to get to someone in crisis before things get really bad. In response to a question about the voluntary nature of the CET proposal, Detective Tinney said the key is not having the treatment forced. He does not think anyone should be involuntarily hospitalized or put into jail if the person is having an episode. In Albuquerque, on average, 300 cases a month are assigned to a CIT; calls for crisis-trained officers are about 3,000 a month. The CIT began as a grant project, Dr. Rosenbaum said, and it reduced calls for service. Now it is part of the Albuquerque Police Department's annual budget. Albuquerque also has three ACT teams, he said, and they can bill Medicaid for services, but then those funds are returned to the city.

Update on the CET Pilot Project

Ms. McWilliams presented information on draft guidelines for the establishment of a CET pilot project. She said the guidelines would be posted on the HSD web site within the next 48 hours. The guidelines are in response to the governor's veto of HB 588 in April. The governor contended that while CETs had merit, the program should not be housed in the Department of Health (DOH), but rather at the HSD. Ms. McWilliams said she has been meeting regularly with clinical service providers and substance abuse experts, as well as members of the HM 45 Task Force, to develop guidelines for good clinical policy.

The CET has to establish clear metrics for desired outcomes, Ms. McWilliams said, such as whether the consumer is participating in outpatient or recovery programs, holding a job or driving a vehicle. Does the consumer perceive improvement, and is there reduced use of the emergency room? Treatment should not be compelled without a determination of incapacity, and

criteria for inclusion or exclusion should be identified. Eligibility should be specified, she said, and clinical and peer leaders should be specified. Peer support workers are paramount to recovery. Ms. McWilliams said that specialized training and protocols for quality improvement must also be included. It is important to know where the levels of care are located within the community, and each community will have its own needs. Quarterly reports should show the cost of services per person and include identified metrics.

Ms. McWilliams described alleged problems with an ACT program in Las Cruces that is for persons 18 years and older who have been diagnosed with mental illness and have undergone repeated hospitalizations. It involves work with an interdisciplinary team. During a recent assessment of former ACT operations by La Frontera in Las Cruces, it reported admission criteria were not available; there was minimal programming on consumer behaviors; punitive measures were being used; there was no access to medical records for 60 clients who are in ACT intensive services; and there were no criteria to move clients to lower levels of care. There is no waiting list for services, and there was significant overstaffing, she said. There was no designated employment specialist, and progress notes were copied and pasted for different clients. There was no discussion of client independence or employment, she said, and clients are being isolated at home. Ms. McWilliams also described licensing issues and poor and inaccurate documentation. She said that a medication audit has occurred. At-risk clients are being medically reevaluated, and clients who are ready to transition to lower levels of care have been identified. Problems that were identified have now been addressed, she said.

Questions/Concerns

One member expressed surprise that the HSD has gone forward with establishing CET guidelines without the accompanying legislation. Ms. McWilliams said that the guidelines, which will be posted very soon for public comment, will help different communities to develop their own guidelines that will meet individual community needs. She was not at the meeting to speak about the legislation, she said. CETs are positive, she said. The BHSD already funds ACT teams and will continue to do this. Another member inquired if all ACT programs are now in compliance with current laws and regulations. ACT teams are all doing the same thing, Ms. McWilliams said. Is she holding the Arizona companies to the same standards?, the member asked. The companies have to use the organizations they are now in charge of managing, she responded, adding that the system needs some technical assistance moving forward for all providers, not just the ones that were audited. Asked how much that will cost, Ms. McWilliams said that the amount is in the current budget request, and this will go out for bid in an RFP. Technical assistance and training are needed to help with the entire statewide network in the transition to Centennial Care, Ms. McWilliams said, but she could not provide the member with the cost because she did not have her budget with her.

Public Comment

Jim Jackson, executive director of Disability Rights New Mexico, spoke positively about CITs and CETs and the emphasis on voluntary services. He also spoke about the 15 audited service providers, insisting that the HSD had discretion before it "pulled the trigger". His

agency's concern is that three months into the transition, the HSD, the collaborative and OptumHealth are failing to live up to their responsibilities to provide services.

Nancy Jo Archer, former director of Hogares, said that the new agencies did offer employment to most of her staff. Afterward, many of them left, so Ms. McWilliams' chart is not accurate. She echoed Ms. Ashcroft's earlier comments about the disruption of trust, and she said OptumHealth's computer system never provided data about the progress of programs and that it was virtually inoperable the first two years and barely any better the next two years. If the HSD could have gone to the AGO with just OptumHealth's audit, why did it spend an additional $3 million?, she asked.

Valerie Romero, a behavioral management specialist at Casa de Corazon in Espanola, said that there are lots of families in Espanola who want to know how to get services. To say that most employees are still with the agency that took over is wrong, she said. Ms. Romero was accompanied by Rocio Trujillo, who told members that without the help of Behavioral Management Services, for which Ms. Romero worked, he could not have gotten his 15-year-old son back in school. Ms. Romero said that as a youth, she was mentally ill herself and that she has a learning disability. Nonetheless, she earned her GED and then a bachelor's degree and is now working on a master's degree in social work. "I see the potential in these kids", she said, and she thanked the subcommittee for the opportunity to be heard.

Evelyn Blanchard, a social worker and an organizer for the New Mexico Center on Law and Poverty, recalled the difficulty of getting Native Americans admitted to the state hospital in 1962 when she began her career. She said it is no different today. The DOH and the HSD have a poor relationship with the tribes, and an atmosphere of collaboration does not exist, she said. Tribes tried to give input for Centennial Care, but it was rejected. The Pueblo of Jemez probably has the premier health facility in the state. It is tenacious and serious about collecting data to determine the kinds and quality of services needed in the community, Ms. Blanchard said. This was offered to the HSD and refused. The premise of Centennial Care was based on unreliable data, she said, and the services are defined by the data the state insists on imposing in Indian country.

Pat Tyrell, director of the National Association of Social Workers, said he appreciated the subcommittee bringing the focus back to behavioral health. "I was profoundly moved by the testimony I just heard and disappointed that at the beginning of the public comment period, the decision-makers and state agency personnel all left", he said. The crisis shows extremely poor planning, he said, and a lack of respect for New Mexico and its cultural traditions. Mr. Tyrell's field is substance abuse. To measure progress, he said, "you have to break through denial". His information differs from that of the party line.

Arlena Ash is a consumer and said she has actually called adult protective services on herself when she was living in unsafe conditions and did not know how to get out. She does not

have the right diagnosis to qualify for ACT, and because of her employment, she is not eligible for Medicaid and is having a hard time.

Krista Scorsone said she is the nurse practitioner that Ms. McWilliams read about in La Frontera's ACT assessment. No one even spoke with her, she said. La Frontera decided to use telemedicine to engage with the ACT population. People who meet criteria for ACT have co-morbidities that cannot be assessed by a television screen, Ms. Scorsone said. If Ms. McWilliams' presentation is so inaccurate, how accurate can the other presentations be?, she asked.

Jamie Campbell is a consumer who lives with schizophrenia and is concerned about access to pre-crisis services. They are not available, there are long wait lists and it can take as long as six months to get an appointment. There needs to be something in between, she said. A person needs a case manager to get into the system, and then there are struggles to get the right services, medications, etc., Ms. Campbell said. She is in favor of peer support workers.

Robert Salazar is a consumer and a representative of the New Mexico's National Alliance on Mental Illness (NAMI). Mr. Salazar wanted to share that recovery is possible. It was very hard for him to accept that he has a mental illness, and it was not until he ended up in the criminal justice system that he finally found the help he needed. During his last incarceration, he was put in a psychiatric unit with treatment and daily support groups. It has been hard to pay for prescriptions, but he finally got a waiver to get his medications for free. Mr. Salazar has had the support of his family, and he feels that this has been extremely important. There are more than 386,000 persons in New Mexico who suffer from mental illness, and a recent study estimates that it costs twice as much to help them inside the justice system as it does outside the justice system, he said. Preventive measures are superior and far less costly than reactive measures, according to Mr. Salazar, who now holds a job with NAMI and is attending school.

Minutes Approved

A motion was made, seconded and passed unanimously to approve the minutes from the July and August meetings. A member noted to the chair that the subcommittee has been promised several different documents by Ms. McWilliams before the next meeting.

The meeting adjourned at 4:30 p.m.